Michigan Maternal-Infant Health Program
Prenatal Risk Factor Screening

1 BASICS/DEMOGRAPHICS

0 SCREENING DATE

MM | DD | YY

1.0 IDENTIFICATION

1.0A NAME

FIRST

MI

LAST

1.0B MEDICAID ID#

1.0C SOCIAL SECURITY#

___ - ___ - ___

1.1 What is your date of birth?

MM DD YY

☐ REFUSED

1.2 What do you identify as your race/ethnic background? (Check all that apply)

☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ White/Caucasian
☐ REFUSED

➡ 1.3

1.3 How many grades of school have you completed?

☐☐ grades completed

Junior high/middle school = 8
High school diploma/GED = 12
Associate's degree = 14
Bachelor's degree = 16

☐ REFUSED

1.4A Do you currently work outside the home?

☐ Yes
☐ No ⇩ 1.5

1.4B How many hours do you work in a typical week?

☐☐ Hours

1.5 Are you currently attending school?

☐ Yes
☐ No

1.6 Are you currently married or unmarried?

☐ Married
☐ Unmarried
☐ REFUSED

➡ 2.1A

2 HEALTH HISTORY/RISKS

2.1A When was your last menstrual period?

MM DD YY ⇩2.2A

☐ DON'T KNOW

☐ REFUSED

2.1B When is your baby due?

MM DD YY

☐ DON'T KNOW

☐ REFUSED

2.2A How do you feel about becoming pregnant? Did you:

☐ Want to be pregnant sooner ⇩2.3

☐ Want to be pregnant later

☐ Want to be pregnant now ⇩2.3

☐ Not want to be pregnant now or at any time in the future

☐ DON'T KNOW ⇩2.3

☐ REFUSED

2.2B At the time you became pregnant, were you using any birth control method?

☐ Yes

☐ No

☐ DON'T KNOW

☐ REFUSED

2.3 What was your weight just before you became pregnant this time?

☐☐☐ Pounds

☐ DON'T KNOW

☐ REFUSED

2.4 What is your height without shoes?

☐ Feet ☐ Inches ➡2.5A

☐ REFUSED

2.5A Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths)

☐ 1 TIME (FIRST PREGNANCY) ⇨2.7

☐ TIMES

☐ REFUSED ⇨2.7

2.5B When did your last pregnancy end? (date of last delivery, abortion, miscarriage or stillbirth)

☐☐ MM ☐☐ YY (Approximate if necessary)

☐ REFUSED

2.6 Did any of your previous pregnancies result in:	YES	PG #	NO
2.6A Miscarriage in the 4th month of pregnancy or later?			
2.6B Stillbirth?			
2.6C Baby weighing less than 5.5 pounds at birth?			
2.6D Baby born more than 3 weeks early (or did anyone tell you that your baby was premature/preterm?)			
2.6E Baby that stayed in the hospital after you went home?			

☐ REFUSED ➡

2.7 Have you ever been treated for or told that you have:

2.7A High blood pressure (hypertension)?

- [ ] No → 2.7B
- [ ] Yes

2.7A.1 When did you last see a health care provider about this problem?

MONTH: YEAR:

2.7A.2 Do you have another visit scheduled?

- [ ] Yes
- [ ] No

2.7A.3 Have you been in the hospital or ER for this problem in the last six months?

- [ ] Yes
- [ ] No → 2.7B

2.7B Anemia or sickle cell disease?

- [ ] No → 2.7C
- [ ] Yes

2.7B.1 Have you ever had a blood transfusion for this problem?

- [ ] Yes — LAST DATE: /
- [ ] No

2.7B.2 When did you last see a health care provider about this problem?

MONTH: YEAR:

2.7B.3 Do you have another visit scheduled?

- [ ] Yes
- [ ] No

2.7B.4 Have you been in the hospital or ER for this problem in the last six months?

- [ ] Yes
- [ ] No → 2.7C

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2.7C Diabetes or high blood sugar?

- [ ] No → 2.7D
- [ ] Yes

2.7C.1 Is it Insulin dependent?

- [ ] Yes
- [ ] No

2.7C.2 When did you last see a health care provider about this problem?

MONTH: YEAR:

2.7C.3 Do you have another visit scheduled?

- [ ] Yes
- [ ] No

2.7C.4 Have you been in the hospital or ER for this problem in the last six months?

- [ ] Yes → 2.7D
- [ ] No

2.7D Asthma?

- ☐ No → ⇩2.7E
- ☐ Yes →

2.7D.1 When did you last see a health care provider about this problem?

MONTH: ____ YEAR: ____ ⬇

2.7D.2 Do you have another visit scheduled?

- ☐ Yes ⬇
- ☐ No

2.7D.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes ⬅2.7E
- ☐ No

2.7E Problems with your heart, kidneys, or lungs?

- ☐ No → ⇩2.7F
- ☐ Yes →

2.7E.1 When did you last see a health care provider about this problem?

MONTH: ____ YEAR: ____ ⬇

2.7E.2 Do you have another visit scheduled?

- ☐ Yes ⬇
- ☐ No

2.7E.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes ⬅2.7F
- ☐ No

2.7F Problems with bleeding?

- ☐ No → ⇩2.7G
- ☐ Yes →

2.7F.1 When did you last see a health care provider about this problem?

MONTH: ____ YEAR: ____ ⬇

2.7F.2 Do you have another visit scheduled?

- ☐ Yes ⬇
- ☐ No

2.7F.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes ⬅2.7G
- ☐ No

2.7G Recurring vaginal infections?

- ☐ No → 2.7H
- ☐ Yes

2.7G.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

2.7G.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

2.7G.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes → 2.7H
- ☐ No

2.7H A sexually transmitted infection?

- ☐ No → 2.7I
- ☐ Yes

2.7H.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

2.7H.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

2.7H.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes → 2.7I
- ☐ No

2.7I Other problems that you see a doctor for?

- ☐ No → 2.8
- ☐ Yes

2.7I.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

2.7I.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

2.7I.3 Have you been in the hospital or ER for this problem in the last six months?

- ☐ Yes
- ☐ No → 2.8A
- ☐ REFUSED

2.8A Are you now taking any prescription drugs?

	Yes	➡
	No	⇩2.9A
	REFUSED	

2.8B Which prescription drugs are you taking?

	⬅2.9A

2.9A How long has it been since you had a dental exam and cleaning?

	Within the past year	⇨3.1
	Within the past 2 years	
	Within the past 5 years	
	More than 5 years ago	➡2.9B
	Don't know/not sure	
	Never	
	REFUSED	

2.9B In the past year, have you noticed any problems with your teeth or gums such as bad breath that won't go away, loose or sensitive teeth, or gums that are red, swollen, tender, or bleeding?

	Yes	➡3.1
	No	

3 PRENATAL CARE

3.1 When you have a health issue or problem, where do you usually go for care?

- ☐ Doctor's office
- ☐ Public health clinic
- ☐ Readicare facility
- ☐ Hospital
- ☐ Emergency room
- ☐ Other
  _____
- ☐ Nowhere
- ☐ REFUSED

3.2 How many months' pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC.

- ☐ ☐☐ Months
- ☐ I haven't gone for prenatal care
- ☐ REFUSED

3.3 Have you had any trouble getting the prenatal care you want or need?

- ☐ Yes
- ☐ No → 3.4
- ☐ REFUSED

3.4 Here is a list of problems some women can have getting prenatal care. For each item, please let us know if it has been true for you at any time during this pregnancy [READ LIST]

- ☐ I couldn't get an appointment when I wanted one
- ☐ I couldn't find a doctor or clinic that accepted Medicaid
- ☐ It is hard to communicate with the doctor or clinic staff
- ☐ It is hard to understand the information the doctor or clinic give to me
- ☐ I haven't had enough money or insurance to pay for my visits
- ☐ I haven't had my Medicaid card or Guarantee of Payment letter
- ☐ I've had no way to get to the clinic or doctor's office
- ☐ I couldn't take time off from work
- ☐ I've had no one to take care of my children
- ☐ I have had too many other things going on in my life
- ☐ I didn't want anyone to know I was pregnant
- ☐ Other. Please tell us:
  _____
- ☐ REFUSED

→ 4.1

4 SMOKING

4.1 Which of the following statements would you say best describes your cigarette smoking? Would you say:

- ☐ I smoke regularly now – about the same amount as before finding out I was pregnant
- ☐ I smoke regularly now, but I've cut down since I found out I was pregnant
- ☐ I smoke every once in a while
- ☐ I have quit smoking since finding out I was pregnant
- ☐ I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes. ⇨5.1
- ☐ REFUSED

4.2 How many cigarettes do you smoke on an average day now/or did before quitting?

- ☐ 1-1/2 or more packs
- ☐ 1 to 1-1/2 packs
- ☐ 1/2 to 1 pack
- ☐ 6 to 10 cigarettes
- ☐ 1 to 5 cigarettes ⇨ 4.4A If smoking
- ☐ Less than 1 cigarette
- ☐ REFUSED

4.3A How soon after you wake up do you smoke your first cigarette?

- ☐ Within 5 minutes
- ☐ 6-30 minutes
- ☐ 31 or more minutes

4.3B Do you find it difficult to stop smoking in non-smoking areas?

- ☐ No
- ☐ Yes

4.3C Which cigarette would you MOST hate to give up?

- ☐ The first cigarette in the morning
- ☐ All others

4.3D Do you smoke MORE FREQUENTLY in the first hours after waking than the rest of the day?

- ☐ No
- ☐ Yes

4.3E Do you smoke if you are so ill that you are in bed most of the day?

- ☐ No
- ☐ Yes

If still smoking:

4.4A Have you seriously thought about quitting smoking during this pregnancy?

- ☐ Yes
- ☐ No ⇨5.1

4.4B Have you tried to quit smoking in the last 30 days?

- ☐ Yes
- ☐ No ⇨5.1

4.4C Have you made any changes or gotten any supports to make it easier for you to not smoke?

- ☐ Yes
- ☐ No ➡5.1

□

5 ALCOHOL

5.1 Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

- ☐ I drink alcohol regularly now – about the same amount as before finding out I was pregnant
- ☐ I drink alcohol regularly now, but I've cut down since I found out I was pregnant
- ☐ I drink alcohol every once in a while
- ☐ I have quit drinking alcohol since finding out I was pregnant → 5.3A
- ☐ I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink. → 6.1
- ☐ REFUSED

5.2 Approximately how many alcoholic drinks do you have in an average week/or did when drinking?

- ☐ 14 drinks or more a week
- ☐ 7 to 13 drinks a week
- ☐ 4 to 6 drinks a week
- ☐ 1 to 3 drinks a week
- ☐ Less than 1 drink a week
- ☐ REFUSED

5.3A How many drinks does it/did it take to make you feel high?

- ☐ 1
- ☐ 2
- ☐ 3 or more

5.3B Have people annoyed you by criticizing your drinking?

- ☐ Yes
- ☐ No

5.3C Have you ever felt you ought to cut down on your drinking?

- ☐ Yes
- ☐ No

5.3D Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

- ☐ Yes
- ☐ No

If still drinking alcohol:

5.4A Have you seriously thought about quitting all alcohol during this pregnancy?

- ☐ Yes
- ☐ No → 6.1

5.4B Have you tried to quit drinking alcohol in the last 30 days?

- ☐ Yes
- ☐ No → 6.1

5.4C Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?

- ☐ Yes
- ☐ No → 6.1

6 DRUG USE

6.1 Does your partner or anyone in your household use street drugs?

- ☐ Yes
- ☐ No
- ☐ REFUSED

⬇

6.2A In the month before you knew you were pregnant, did you use any street drugs, diet pills, or drugs not prescribed by a physician?

- ☐ Yes ⬇ 6.2B
- ☐ No ⇨ 7.1
- ☐ REFUSED

6.2B What did you use? (check all that apply)
[OPEN ENDED, PROMPT FOR OTHERS]

- ☐ Marijuana
- ☐ PCP
- ☐ Crack
- ☐ Cocaine
- ☐ Heroin
- ☐ Uppers/Crank/Meth/Speed
- ☐ Downers
- ☐ LSD
- ☐ Diet Pills
- ☐ Prescription drugs not prescribed for you
- ☐ Other:

⬇

6.2C What drugs have you used since becoming pregnant? (check all that apply)
[OPEN ENDED, PROMPT FOR OTHERS]

- ☐ Marijuana
- ☐ PCP
- ☐ Crack
- ☐ Cocaine
- ☐ Heroin
- ☐ Uppers/Crank/Meth/Speed
- ☐ Downers
- ☐ LSD
- ☐ Diet Pills
- ☐ Prescription drugs not prescribed for you
- ☐ Other:
- ☐ None

⬇

If still using drugs:

5.4A Have you seriously thought about quitting all drugs during this pregnancy?

- ☐ Yes
- ☐ No

5.4B Have you tried to quit using drugs in the last 30 days?

- ☐ Yes
- ☐ No

5.4C Have you made any changes or gotten any supports to make it easier for you to not use drugs?

- ☐ Yes
- ☐ No

7 STRESS

7.1 **In the last month, how often have you felt nervous and stressed?**

- ☐ Never → 8.1
- ☐ Almost Never
- ☐ Sometimes
- ☐ Fairly Often
- ☐ Very Often
- ☐ REFUSED → 8.1
- ☐ SNAG

7.2 **During pregnancy, pressures and hassles of everyday life can become even harder to cope with. In the last month, have you felt like you were struggling to cope with:**

	YES	NO
Problems with money?	☐	☐
Problems with a personal relationship?	☐	☐
Demands of family or children?	☐	☐
Demands of work or school?	☐	☐

→

7.3A **In the last month, how often have you felt that you were unable to control the important things in your life?**

- ☐ Never
- ☐ Almost never
- ☐ Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3B **In the last month, how often have you felt confident about your ability to handle your personal problems?**

- ☐ Never
- ☐ Almost never
- ☐ Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3C **In the last month, how often have you felt that things were going your way?**

- ☐ Never
- ☐ Almost never
- ☐ Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3D **In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?**

- ☐ Never
- ☐ Almost never
- ☐ Sometimes
- ☐ Fairly often
- ☐ Very often

→ 8.1

8 DEPRESSION AND MENTAL HEALTH

8.1 Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Not at all
- ☐ * Several days
- ☐ * More than half the days
- ☐ * Nearly every day
- ☐ REFUSED

8.2 Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Not at all
- ☐ * Several days
- ☐ * More than half the days
- ☐ * Nearly every day
- ☐ REFUSED

8.3 Over the past 2 weeks, how often have you had 'nerves' or felt angry, blue, or out of sorts?

- ☐ Not at all
- ☐ * Several days
- ☐ * More than half the days → 8.4
- ☐ * Nearly every day
- ☐ REFUSED

8.4A Have you ever had the "baby blues"?

- ☐ Yes
- ☐ No
- ☐ REFUSED

8.4B Have you ever been treated for or told that you have depression, bipolar disorder, or schizophrenia?

- ☐ No ⇩ BELOW
- ☐ Yes → 8.4B.1

8.4B.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

8.4B.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

8.4B.3 Have you been in the hospital or ER for this condition in the last six months?

- ☐ Yes
- ☐ No → BELOW

IF ONE OR MORE ANSWERS TO 8.1 – 8.3 ARE MARKED ★, CONTINUE TO 8.5.

OTHERWISE, SKIP TO 9.1

QUESTIONS 8.4 – 8.13: DEPRESSION FOLLOW UP SCREENING

I'd like to ask you some follow up questions about how you're feeling.
I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

	8.5 I have been able to laugh and see the funny side of things
	As much as I always could
	Not quite so much now
	Definitely not so much now
	Not at all

	8.6 I have looked forward with enjoyment to things
	As much as I ever did
	Rather less than I used to
	Definitely less than I used to
	Hardly at all

	8.7 I have blamed myself unnecessarily when things went wrong
	Yes, most of the time
	Yes, some of the time
	Not very often
	No, never

	8.8 I have been anxious or worried for no good reason
	No, not at all
	Hardly ever
	Yes, sometimes
	Yes, very often

	8.9 I have felt scared or panicky for no very good reason
	Yes, quite a lot
	Yes, sometimes
	No, not much
	No, not at all

	8.10 Things have been getting the best off me
	Yes, most of the time I haven't been able to cope at all
	Yes, sometimes I haven't been coping as well as usual
	No, most of the time I have coped quite well
	No, I have been coping as well as ever

	8.11 I have been so unhappy that I have had difficulty sleeping
	Yes, most of the time
	Yes, sometimes
	Not very often
	No, not at all

	8.12 I have felt sad or miserable
	Yes, most of the time
	Yes, quite often
	Not very often
	No, not at all

	8.13 I have been so unhappy that I have been crying
	Yes, most of the time
	Yes, quite often
	Only occasionally
	No, never

	8.14 The thought of harming myself has occurred to me
	Yes, quite often
	Sometimes
	Hardly ever
	Never

9	SOCIAL SUPPORT

9.1	Would you describe the father of this baby as:	
	Involved in my pregnancy and supportive of me	
	Involved but not supportive of me	
	Aware that I'm pregnant but not involved	
	Not aware that I'm pregnant	
	REFUSED	

9.2A	Is there someone in your life who you can count on to help you during this pregnancy and with your new baby?	
	Yes	
	No	⇨10.1

9.2B	Who do you count on for support? (check all that apply)	
	Partner and/or the baby's father	
	Parent(s)	
	Other child or children	
	Other relative(s)	➡10.1
	Friend(s)/Neighbor(s)	
	Clergy and/or people at my place of worship	
	Other:	

10 ABUSE/VIOLENCE

10.1 Do you feel safe in your present relationship?

- ☐ I am not in a relationship right now
- ☐ Yes
- ☐ No

10.2A Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?

- ☐ Yes
- ☐ No ⇨10.4

10.2B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify_____

10.2C How many times has this happened?

- ☐ times

10.3A Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- ☐ Yes
- ☐ No ⇨10.4

10.3B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify:

10.3C How many times has this happened?

- ☐ times

10.3D What part or parts of your body were hurt?

- ☐ Limbs
- ☐ Torso
- ☐ Head

➡10.3E

10.3E How did this person hurt you? (Score the most severe incident to the following scale):

- ☐ Threats of abuse, including use of a weapon
- ☐ Slapping, pushing; no injuries and/or lasting pain
- ☐ Punching, kicking, bruises, cuts and/or continuing pain
- ☐ Beaten up, severe contusions, burns, broken bones
- ☐ Head, internal, and/or permanent injury
- ☐ Use of weapon, wound from weapon

10.4 Has your partner or someone else now in your life:

- ☐ Belittled you, humiliated you, or made you feel that you don't count?
- ☐ Isolated you from your friends, family, groups, or other people?
- ☐ Thrown away your belongings, destroyed objects, threatened pets, or done other things to scare you?
- ☐ Controlled your access to money or work?

10.5A Within the past year, has anyone forced you to have sexual activities?

- ☐ Yes
- ☐ No ⇩10.6

10.5B Who was it?

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- Specify:

10.5C How many times has this happened?

- ☐ times

10.6 Have you *ever* been emotionally or physically abused by your partner or someone important to you?

- ☐ Yes
- ☐ No

10.7 Are you afraid of your partner or anyone you listed above?

- ☐ Yes
- ☐ No

➡11.1A

11 BASIC NEEDS

11.1A In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

	Yes	⇩
	No	⇩11.2

11.1B How often did this happen?

	Almost every month	⇩
	Some months but not every month	
	In only 1 or 2 months	

11.2 How many times have you moved in the past 12 months?

	0	⇩
	1	
	2	
	3	
	4 or more	

11.3A Do you currently have any concerns or worries about your housing situation?

	Yes	⇩
	No	⇨11.4

11.3B What are your concerns or worries about housing? (check all that apply)
[OPEN ENDED]

Instability		
	No place to live, no regular night time residence, or live in a shelter.	
	Eviction or being forced to move out.	
	Affordability of current house or apartment	
	Strained relations with others in household	⇨11.4
Adequacy		
	House or apartment is too crowded.	
	Lack of continuous functioning basic utility service (e.g., heat, electricity)	
Safety		
	Safety of house/apartment	
	Safety of neighborhood	

11.4 How often do you have access to a telephone to make and receive calls where you live?

	Always	⇩
	Sometimes	12.1
	Never	

12 BREASTFEEDING

12.1 Which of the following best describes your thoughts on breastfeeding your new baby?

	I know I will breastfeed
	I think I might breastfeed
	I know I will not breastfeed
	I don't know what to do about breastfeeding
	REFUSED

END